CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: WWW.DPR.DELAWARE.GOV

BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

AFFIDAVIT AND RELEASE OF INFORMATION

(For Reciprocity Applications)

The undersigned applicant for Professional Counselor of Mental Health licensure, being sworn, deposes and affirms that the following is a complete list of any and all licensing jurisdictions in which s/he has formerly and currently practiced as a licensed mental-health professional. The applicant hereby authorizes all such jurisdictions to release any and all information regarding his/her disciplinary history and current status to the Delaware Board of Mental Health and Chemical Dependency Professionals.

1. Jurisdiction: _____ Type of License: _____

   Name of Licensee as it Appears on License: _____

   Dates of Licensure: _____ to _____

   Name of Licensure Authority: _____

   Address: _____ Phone: _____

   _____ Zip Code: _____

2. Jurisdiction: _____ Type of License: _____

   Name of Licensee as it Appears on License: _____

   Dates of Licensure: _____ to _____

   Name of Licensure Authority: _____

   Address: _____ Phone: _____

   _____ Zip Code: _____

3. Jurisdiction: _____ Type of License: _____

Name of Licensee as it Appears on License: _____

Dates of Licensure: _____ to _____

Name of Licensure Authority: _____

Address: _____ Phone: _____

_____ Zip Code: _____

4. Jurisdiction: _____ Type of License: _____

Name of Licensee as it Appears on License: _____

Dates of Licensure: _____ to _____

Name of Licensure Authority: _____

Address: _____ Phone: _____

_____ Zip Code: _____

_____

Signature of Applicant

State of _____

City of _____ County of _____

Sworn to me before me this _____ day of _____, 19____.

My commission expires _____

_____

Signature of Notary Public

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BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

VERIFICATION OF LICENSURE FROM ANOTHER STATE

To: _____

_____

_____

The applicant named below has applied for licensure by reciprocity as a Professional Counselor of Mental Health (LPCMH) or an Associate Counselor of Mental Health (LACMH) in the State of Delaware. In order to properly evaluate his/her application, the Board of Mental Health and Chemical Dependency Professionals requests the following information:

1. Verification of applicant's current licensure in good standing and date of initial licensure;
2. A copy of the current statute(s); and
3. A copy of the current rules and regulations.

Please verify the applicant's licensure and standing by completing Part 2 of this form and returning it with the documents listed above to the Delaware Board of Professional Mental Health and Chemical Dependency Professionals at the address above. Thank you in advance for your assistance.

Part 1 - To be Completed by Applicant

Name: _____ Phone: _____

Address: _____

_____ Zip Code: _____

Licensed as: _____

License No.: _____ Date Licensed: _____ Expiration Date: _____

I hereby authorize _____ to release information regarding my certification to the Delaware Board of Mental Health and Chemical Dependency Professionals.

_____ _____

Signature of Applicant Date

Part 2 - To be Completed by Licensure Authority:

A. Is the applicant currently certified as represented above? Yes _____ No _____

B. Is the applicant currently in good standing? Yes _____ No _____

If the answer to either of the above is "no," please give full particulars: _____

_____

_____

_____

C. Has the applicant ever been disciplined or penalized for any violation of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence? Yes _____ No _____

D. Are any complaints, charges or investigations pending against the applicant for violation of ethics codes, professional misconduct, unprofessional conduct, incompetence or negligence? Yes _____ No _____

If the answer to either of the above is "yes," please give full particulars: _____

_____

_____

Enclosed are the following documents:

Current Statute(s) Yes _____ No _____

Current Rules and Regulations Yes _____ No _____

Name of Official: _____ Title: _____

Name of Licensure Authority: _____

Address: _____ Phone: _____

_____ Zip Code: _____

_____ _____

Signature of Official of Licensure Authority Date